

## Centers for Medicare & Medicaid Services, HHS

## § 447.90

(1) Limit a hospital's obligations with respect to screening and stabilizing treatment of an emergency medical condition under section 1867 of the Act; or

(2) Modify any obligations under either State or Federal standards relating to the application of a prudent-layperson standard with respect to payment or coverage of emergency medical services by any managed care organization.

[73 FR 71851, Nov. 25, 2008, as amended at 75 FR 30265, May 28, 2010]

### § 447.82 Restrictions on payments to providers.

(a) The plan must provide that the State Medicaid agency reduces the payment it makes to a provider by the amount of a beneficiary's cost sharing obligation, regardless of whether the provider successfully collects the cost sharing.

(b) Payment that is due under Medicaid to an Indian health care provider or a health care provider through referral under contract health services for directly furnishing an item or service to an Indian may not be reduced by the amount of any enrollment fee, premium, or similar charge, or any deductible, copayment, cost sharing, or similar charge that otherwise would be due.

(c) The plan must describe how the State identifies for providers, ideally through the use of the automated systems, whether cost sharing for a specific item or service may be imposed on an individual beneficiary and whether the provider may require the beneficiary, as a condition for receiving the item or service, to pay the cost sharing charge.

[75 FR 30265, May 28, 2010]

### ALTERNATIVE PREMIUMS AND COST SHARING UNDER SECTION 1916A

### § 447.88 Options for claiming FFP payment for section 1920A presumptive eligibility medical assistance payments.

(a) The FMAP rate for medical assistance payments made available to a child during a presumptive eligibility period under section 1920A of the Act is the regular FMAP under title XIX,

based on the category of medical assistance; that is, the enhanced FMAP is not available for section 1920A presumptive eligibility expenditures.

(b) States have the following 3 options for identifying Medicaid section 1920A presumptive eligibility expenditures and the application of payments for those expenditures:

(1) A State may identify Medicaid section 1920A presumptive eligibility expenditures in the quarter expended with no further adjustment based on the results of a subsequent actual eligibility determination (if any).

(2) A State may identify Medicaid section 1920A presumptive eligibility expenditures in the quarter expended but may adjust reported expenditures based on results of the actual eligibility determination (if any) to reflect the actual eligibility status of the individual, if other than presumptively eligible.

(3) A State may elect to delay submission of claims for payments of section 1920A presumptive eligibility expenditures until after the actual eligibility determination (if any) is made and, at that time identify such expenditures based on the actual eligibility status of individuals if other than presumptively eligible. At that time, the State would, as appropriate, recategorize the medical assistance expenditures made during the section 1920A presumptive eligibility period based on the results of the actual eligibility determination, and claim them appropriately.

[65 FR 33622, May 24, 2000]

### § 447.90 FFP: Conditions related to pending investigations of credible allegations of fraud against the Medicaid program.

(a) *Basis and purpose.* This section implements section 1903(i)(2)(C) of the Act which prohibits payment of FFP with respect to items or services furnished by an individual or entity with respect to which there is pending an investigation of a credible allegation of fraud except under specified circumstances.

(b) *Denial of FFP.* No FFP is available with respect to any amount expended for an item or service furnished by any individual or entity to whom a State